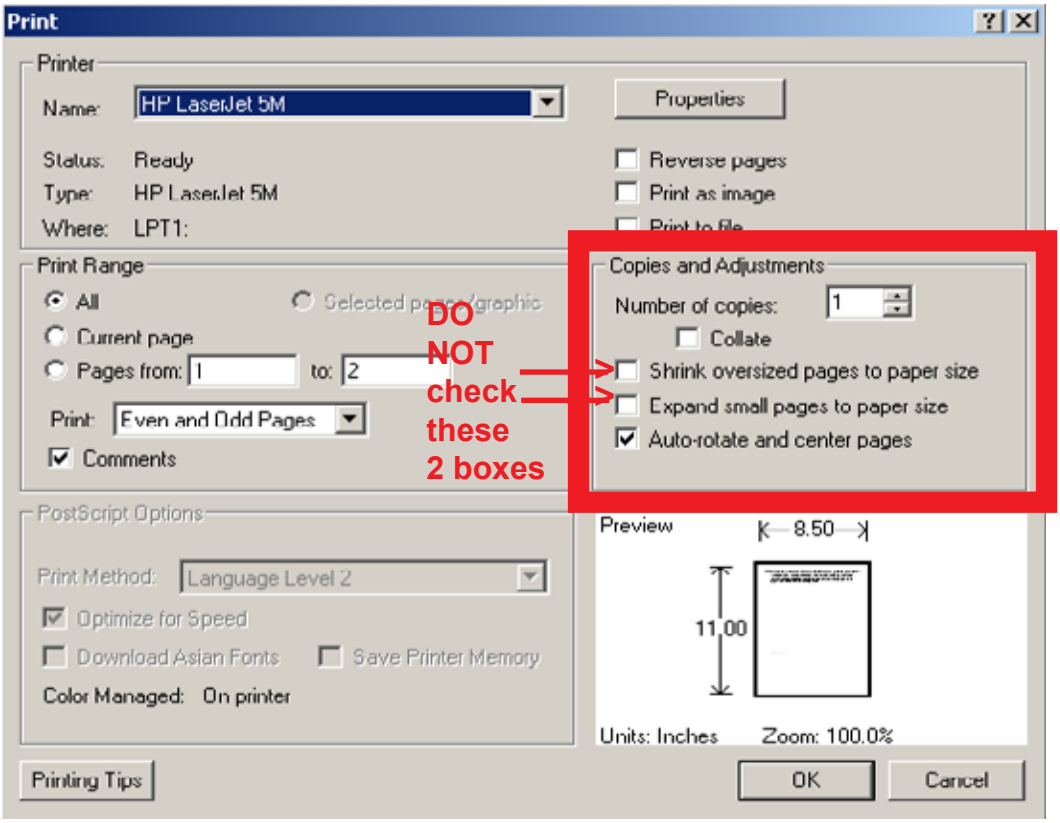
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (3/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Occupational Therapist Endorsement License Application Packet

1. 683-047 ... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 683-026 ... Occupational Therapist or Occupational Therapy Assistant Instructions and Checklist .... 4 pages
3. 683-025 ... Application for Occupational Therapist or Occupational Therapy Assistant ..... 4 pages
4. OT Jurisprudence Exam ..... 2 pages
5. 683-039 ... Employment Verification/Affidavit For Internationally Educated Occupational Therapist and Occupational Therapy Assistant Applicants ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Occupational Therapist
(Endorsement)

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 683-047 (3/2006)

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Keep these Instructions For Future Reference

Washington State Department of Health
PO Box 47867
Olympia, WA 98504-7867
360/236-4700

Occupational Therapist or Occupational Therapy Assistant Application Instructions and Checklist

When your application for an occupational therapy or occupational therapy assistant license has been received by the Department of Health, you will be sent an acknowledgment letter noting any outstanding documentation needed to complete your application. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment letter. Your cooperation is needed to allow the Board's staff time to prepare your file and issue your license at the earliest possible time.

If you have accepted employment as an occupational therapist or occupational therapy assistant, we advise you to inform your employer of the approximate application processing times listed below:

Interstate endorsement applicants	Allow 6-8 weeks
Examination Applicants	Allow 6-8 weeks
*Limited permit applicants	Allow 4-6 weeks
Internationally educated applicants	Allow 10-12 weeks (see page 3)

Note: The above processing times are estimates and are determined when required documentation is received. Once all required documents are received, it may take up to 14 days for your license to be issued.

* A **Limited Permit** is available only to new graduates who are awaiting the National Board for Certification in Occupational Therapy (NBCOT, formerly AOTCB) examination or results and have graduated from an approved program. Please refer to RCW 18.59.040(7) and WAC 246-847-010(8) and WAC 246-847-115.

You may not provide services as an occupational therapist or occupational therapy assistant until you have received your Washington license. Please be advised that during the application process, information pertaining to the status of your application is available only to you.

To ensure that the necessary fees and documentation have been submitted or requested by you, we encourage you to use the following checklist:

☐ **Completed application**. *(all applicants)*

☐ ***Nonrefundable* application fee.** *(all applicants)* Make your check payable to the Department of Health. Your application and fee must be mailed to the Department of Health, P.O. Box 1099, Olympia, WA 98507-1099.

Full license only	$125.00
Limited permit and full license	$165.00

Keep these Instructions For Future Reference

☐ **Official transcript.** *(all applicants)* Your transcript must indicate successful completion of your fieldwork and your degree conferred and must be sent directly from your school to us. *Transcripts will only be accepted if mailed to this office from your school.* **If you were internationally educated, please see page 3 for special instructions.**

☐ **Jurisprudence Examination.** *(all applicants)* Study the Washington State Occupational Therapy Practice Laws (RCW 18.59 and WAC 246-847) and circle the correct response to each question. Current laws can be located at: https://fortress.wa.gov/doh/hpqa1/hps3/Occupational_Therapy/laws.htm.

☐ **AIDS Education and Training Attestation (within the application).** *(all applicants)* Before you can be licensed, you must attest on the enclosed application that you have completed seven (7) hours of AIDS education as defined in WAC 246-847-190.

It is your responsibility to obtain coursework that meets Washington requirements. If your college curriculum did not contain the required coursework, you may be able to locate available courses through employers, community colleges, professional associations, local health departments, or hospitals and/or at http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/training.htm.

☐ **Letter from your school.** *(Limited permit applicants)* If you are a recent graduate applying for a Limited Permit and your transcripts are not yet available, you may be issued a Limited Permit upon submission of a letter from your program director verifying successful program completion and date of graduation. **A full license, however, will not be issued to you until an official transcript has been received.** *The letter will only be accepted if mailed directly to this office from your program director.*

☐ **Verification of being scheduled to take the NBCOT exam. (Limited Permit Applicants)** If you are applying for a Limited Permit, you must sign and date the Limited Permit Attestation portion of the application. Your sponsor is also required to sign and date the Limited Permit Attestation portion of your application. It is **YOUR** responsibility to contact NBCOT. Examination dates and deadlines are established by NBCOT and are strictly adhered to. NBCOT can be contacted at www.nbcot.org or (301) 990-7979.

☐ **Letter of good standing.** *(interstate endorsement applicants)* If you are an interstate endorsement applicant, you must have the National Board for Certification in Occupational Therapy send a letter of good standing and/or verification of having passed the NBCOT examination directly to us. *Letters of good standing will only be accepted if mailed to this office from the National Board for Certification in Occupational Therapy (NBCOT).*

To have verification sent to this office, contact the National Board for Certification in Occupational Therapy, Inc., 800 S. Frederick, Suite 200, Gaithersburg, MD 20877-4150 or call (301) 990-7979 or www.nbcot.org.

☐ **Verification of licenses.** *(interstate endorsement applicants)* If you are applying by interstate endorsement, request that all state boards where you have ever held a health care practitioner license send written verification of your license(s) directly to us. *Verifications will only be accepted if mailed to this office from the state board office.*

Internationally Educated Applicants

If you were educated outside the United States, you must supply the following information in addition to the items listed on the preceding pages. Be advised that further documentation may be required in addition to the documents listed below.

Important Note: Once all documentation is received, the completed application and supporting documents must be presented to the full Board for decision according to WAC 246-847-120 Foreign trained applicants. Scheduled Board meetings are listed on our website at https://fortress.wa.gov/doh/hpqa1/hps3/Occupational_Therapy/default.htm under Minutes. All documents must be received in our office 30 days prior to scheduled Board meeting.

☐ An official description of the educational program where your occupational therapy degree was earned and, if the description is not in English, an English translation signed by the translator must be submitted with the official description. *This document will only be accepted if sent to this office directly from the school.*

☐ An official transcript (including grades and grading key) sent directly from your school and, if the transcript is not in English, an English translation signed by the translator must be submitted with the official transcript.

☐ Verification of licenses. Request all jurisdictions or regulatory bodies where you have ever held a health care practitioner license to send written verification of your licenses directly to us. *Verifications will only be accepted if mailed to this office directly from the issuing agency of origin.*

☐ Complete Part I of the enclosed Affidavit/Employment Verification form for every position held as an occupational therapist or occupational therapy assistant within the past three years

and

Have each employer complete Part II of the Affidavit/Employment Verification form for every position held as an occupational therapist or occupational therapy assistant within the past three years. *Verifications will only be accepted if mailed to this office from the employer or direct supervisor.*

Please be advised that all applications and all supporting documents are held for one year only from the date of receipt. Applicants who have not obtained licensure within one year of submitting application to the Department of Health must reapply, including payment of application fees.

Keep these Instructions For Future Reference

Washington State Law and Department of Health policy prohibits employees from receiving any gifts, gratuities and/or favors. Any offer of private benefit to an employee that is intended to influence a public decision is bribery and violates Federal and State Law. (RCW 42.18.320(2)).

Application and fee should be sent to:

DEPARTMENT OF HEALTH
Occupational Therapy Program
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be mailed to:

DEPARTMENT OF HEALTH
Occupational Therapy Program
P.O. Box 47867
Olympia, WA 98504-7867
(360) 236-4700

The Customer Service Center may be contacted at (360) 236-4700.

Occupational Therapy Practice Board's Fax Number is (360) 664-9077.

Most applicant questions can be answered at our website:

https://fortress.wa.gov/doh/hpqa1/hps3/Occupational_Therapy/default.htm

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application For Occupational Therapist
Occupational Therapy Assistant

LICENSE #

Application as an: ☐ Occupational Therapist ☐ Occupational Therapy Assistant

Application for:
☐ Original license (I have taken the NBCOT exam but am not licensed/registered.)
☐ Interstate Endorsement (I am licensed/registered in another state.)
☐ Limited Permit (I am a recent graduate awaiting the exam/results.)

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by the applicable, nonrefundable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male		

Have you ever applied for a Washington license before? ☐ Yes ☐ No

If yes, list date(s):

Have you ever been known by any other name? ☐ Yes ☐ No

If yes, list.

2. Previous Licensure

List **all** states and/or jurisdictions, U.S. and foreign, in which you have any health care practitioner licenses. Please list all active, inactive and expired licenses. Please list license type. Please request that the state and/or jurisdiction send official verification directly to this office.

☐ I have never been registered, certified or licensed to practice occupational therapy in any jurisdiction.

STATE/JURISDICTION	LICENSE TYPE	LICENSE		EXPIRATION DATE
		YEAR ISSUED	NUMBER	

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Education

In chronological order, list **all** professional education including college, university, technical or professional training pertaining to the practice of occupational therapy.

Request that your school or program send an official transcript to this office.

FULL NAME OF APPROVED SCHOOL CITY, STATE AND COUNTRY	ATTENDANCE		DEGREE/CERTIFICATE & DATE RECEIVED
	ENTERED (MO/YR	COMPLETED (MO/YR)	

5. NBCOT Certification (National Board for Certification in Occupational Therapy)

If you are an interstate endorsement applicant, or an individual who has taken and passed the NBCOT exam, but never licensed, request a letter verifying that your certification is (was) in good standing.

Certification Number

Certification is: ☐ Current
☐ Not current due to: ☐ Nonrenewal
☐ Other (attach explanation)

6. Employment

Beginning with current employment, list **all** activities and account for **all** periods of time from graduation to the present time (attach additional information, if necessary).

BEGIN DATE	END DATE	EMPLOYER/ACTIVITIES	ADDRESS/TELEPHONE NUMBER	TITLE

7. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Limited Permit/Sponsor Information (Your sponsor must hold a current Washington OT License.)

The following section must be completed by your sponsoring occupational therapist **if you wish to work as an occupational therapist/assistant** until release of your examination scores. A **limited permit** cannot be issued without this information. NBCOT's Authorization to Test (ATT) letter is valid for 90 days and the applicant must test within that time frame.

Date _____

Name of Employer _____ Telephone _____

Employer's Address _____

City _____ State _____ Zip _____

Sponsor's Name _____ License No. _____

I have read Chapter 18.59 RCW and 246-847 WAC and agree to sponsor the above named applicant.

Signature of Sponsor _____ Date _____

9. Limited Permit Attestation (To be Completed by Applicant)

I certify that I fully understand it is my responsibility to take the NBCOT examination within the 90 days of my valid Authorization to Test (ATT) letter, and to have NBCOT send my exam scores to Washington State Occupational Therapy Practice Board. I further understand that if I should fail to do the above items my Limited Permit will become invalid. I am aware that Limited Permits become invalid upon exam failure or 30 days after notification of a passing

APPLICANT'S INITIALS	DATE

10. Applicant's Attestation

I, _____ , certify that I am the person described and identified in this
Name of Applicant
application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act, and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my credential to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

Washington State Occupational Therapy Practice Board

Jurisprudence Examination

Please circle the correct response

1. Under RCW 18.130.180, WAC 246-847-160 and WAC 246-847-180, which of the following behaviors may result in disciplinary action:

   a. Sexual misconduct
   b. Fraudulent billing practices
   c. Failure to report unprofessional conduct by another occupational therapist
   d. All of the above

2. Supervision and regular consultation of an occupational therapy assistant by an occupational therapist is defined by:

   a. WAC 246-847-010(2)
   b. The Secretary of the Department of Health
   c. RCW 18.59.005

3. Under WAC 246-847-010, supervision is defined in the WACs, in part, as:

   a. The supervising occupational therapist reviewing documentation
   b. Face-to-face meetings with the occupational therapist and the occupational therapy assistant
   c. The supervising occupational therapist being on the premises
   d. The supervising occupational therapist is available for telephone consultation

4. As specified in RCW 18.59.020(4) and WAC 246-847-010(2), the supervising occupational therapist is responsible for the service provided by the occupational therapy assistant.

   a. True
   b. False

5. Under the UDA, RCW 18.130.050, the Board has the following authority:

   a. To adopt standards of professional conduct or practice
   b. To use individual members of the Board to direct investigations
   c. To grant or deny license applications
   d. All of the above
   e. None of the above

6. If you are planning to move, you must: *(See bottom of page for answer)*

   a. Count on the post office to forward your license renewal
   b. Call the Department of Health with the new address
   c. Assume your personnel department will notify the proper people
   d. Send a change of address card to the Department of Health, including name, license number, date of birth, old and new address listed, and your profession (OT or OTA)
   e. b or d

7. Licenses need to be renewed as defined in WAC 246-847-990:

   a. Every two years on or before your birthday
   b. Every fifth year if you work for the schools
   c. Whether you get a notice or not
   d. On a one-time basis only
   e. Both a and c

8. As defined in RCW 18.59.031 and WAC 246-847-080(8), which of the following is required to practice occupational therapy in the State of Washington:

   a. Passing score on the NBCOT examination
   b. Your supervisor to vouch for you
   c. Washington State driver's license
   d. Washington State occupational therapy license
   e. Both a and d

9. You are formulating a method to ensure professional accountability in your department. Where in the lawbook will you find help?

   a. WAC 246-847-010
   b. WAC 246-847-080
   c. WAC 246-847-170
   d. RCW 18.130.010
   e. Both a and c

(Over)

10. Evidence of continued competency as defined in WAC 246-847-065 can be obtained through which of the following methods:

    a. Inservices
    b. Course work
    c. Conferences
    d. Workshops
    e. All of the above

11. A person who places his or her license on inactive status as defined in WAC 246-847-070 may resume active practice upon paying renewal fees and showing completion of continued competency requirements.

    a. True
    b. False

12. As defined in WAC 246-847-190, occupational therapists must show proof of AIDS education and training prior to receiving a license.

    a. True
    b. False

13. As defined in WAC 246-847-190, how many hours of AIDS education and training are required before a health professional can obtain a license?

    a. 6
    b. 8
    c. 12
    d. 16

14. An occupational therapist, under WAC 246-847-170, may treat a client without seeking medical direction when:

    a. There is a physical therapy referral
    b. Your director tells you it's policy
    c. There is absence of pathology
    d. You are highly qualified

15. Under RCW 18.130.180 and WAC 246-847-160, which of the following is considered unprofessional conduct and subject to disciplinary action:

    a. False, fraudulent or misleading advertising
    b. Sexual misconduct
    c. Addiction to drugs or alcohol
    d. All of the above

16. An occupational therapist or occupational therapy assistant, as specified in WAC 246-847-170, may perform which of the following services:

    a. EEG
    b. Ultrasound
    c. Only those techniques for which you are qualified by education, training or experience
    d. b and c

17. RCW 18.59.020(5) means:

    a. Patients can perform their own therapy after training and be billed for it if the secretary is present
    b. Your receptionist can start the initial evaluation if she understands the forms and is highly dependable
    c. Aides can be trained specifically with each client, to perform ADL training
    d. Both a and d

18. You forgot to renew your license and now your birthday has passed. As soon as you are aware of this, you immediately send in your check. As specified in RCW 18.59.031, in the time between your birthday and receiving your license, can you practice occupational therapy?

    a. Yes
    b. No

Key:

1. D
2. A
3. B
4. A
5. D
6. E
7. E
8. E
9. E
10. E
11. A
12. A
13. A
14. C
15. D
16. C
17. C
18. B

Washington State Department of Health
P.O. Box 47867
Olympia, WA 98504-7867

Employment Verification/Affidavit For Internationally Educated Occupational Therapists And Occupational Therapy Assistants

(This form to be filled out by Internationally educated applicants ONLY as required by WAC 246-847-120)

NAME OF FACILITY			
NAME OF DIRECT SUPERVISOR		TITLE OF DIRECT SUPERVISOR	
STREET ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER`

(This section to be completed by applicant)

Applicant **must** complete this affidavit for **each place of employment** during the three years immediately prior to the date of application for a Washington license. You may duplicate this form as necessary.

I certify that I provided occupational therapy services at the facility named above during the time period:

BEGINNING DATE	ENDING DATE:

The capacity in which I was employed; including job title, specific duties, and nature of clientele are listed below:

JOB TITLE	SPECIFIC DUTIES	NATURE OF CLIENTELE

I certify that the information that I provided above is true to the best of my knowledge. I understand that should I provide any false information, my license may be denied, suspended or revoked.

SIGNATURE _____ DATE _____

(This section to be completed by supervisor/personnel manager and returned to the above address)

I certify that _____ (NAME OF APPLICANT) satisfactorily provided services at this facility in the capacity of an occupational therapist/occupational therapy assistant during the time period:

BEGINNING DATE	ENDING DATE:

List his/her specific duties:

NAME OF PERSON COMPLETING THIS FORM (PRINTED)	SIGNATURE	DATE

TITLE OF PERSON COMPLETING THIS FORM (PRINTED)	TELEPHONE NUMBER ( )